

CLINICAL LECTURE

ON

AN OBSCURE TUMOR OF THE ABDOMEN—AMPUTATION OF THE BREAST
FOR PAGET'S DISEASE FOLLOWED BY CANCER—TUBERCU-
LOSIS OF THE TONSIL AND SOFT PALATE, BY A
METHOD WHICH AVOIDED SPLITTING OF THE
CHEEK OR DIVIDING THE JAW.

DELIVERED AT THE

JEFFERSON MEDICAL COLLEGE HOSPITAL

BY

W. W. KEEN, M.D.,

Professor of the Principles of Surgery and of Clinical Surgery, Jefferson Medical College.

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Surgical Clinic.

OBSCURE TUMOR OF ABDOMEN— AMPUTATION OF BREAST FOR PAGET'S DISEASE FOLLOWED BY CANCER—TUBERCULOSIS OF TONSIL AND SOFT PALATE; OPERATION BY A METHOD WHICH AVOIDED SPLITTING OF THE CHEEK OR DIVIDING THE JAW.

Delivered at the Jefferson Medical College Hospital, November
25, 1896,

BY PROF. W. W. KEEN, M. D.

The first case I shall show you is a man with an

OBSCURE TUMOR IN THE EPIGASTRIUM, who has been examined at my request by my colleague, Prof. James C. Wilson, from the medical standpoint as well as by myself from the surgical.

Please remember, gentlemen, no matter how much knowledge you have you will not uncommonly run across obscure cases. Never hesitate for a moment to say they are obscure, and to ask for a consultation with one in whose judgment and acute clinical powers you have confidence, as I have in those of Prof. Wilson.

You will remember that this man was before you three weeks ago. I show him now in order that you may observe the effect of treatment, and to show you that the tentative diagnosis we then made is, without much doubt, correct. His history, you may remember, was as follows :

O. D., age thirty-seven, was admitted to the Jefferson Hospital Nov. 2, 1896. His family and personal history have been very good, with the exception of the fact that he has had 4 attacks of gonorrhœa and 5 chancroids with suppurating buboes in each groin about five years ago. He denies any primary syphilitic attack or secondary symptoms. His present trouble began about one year ago with pain in the epigastric region, which also was felt, but to a less extent, in both hypochondriac regions. The attacks have been

irregular, the intervals being from one day to about two weeks. Occasionally during the last summer he had attacks of vomiting on rising, the fluid ejected being practically clear. He has never vomited blood nor has he ever passed blood in his stools. His weight is practically the same as it has been for a number of years. His appetite is good; bowel movements regular. His food has never lain any length of time in his stomach.

On examination, a hard, nodular tumor, apparently about 1 by 1½ inches, is felt in the epigastrium just beneath the abdominal wall, or possibly even in it. It is slightly tender, and dull on percussion. The dulness is continuous with that of the liver, which extends about 2 inches below the border of the ribs. He has never had jaundice. On November 4th the stomach was emptied, a test meal given him, and free hydrochloric acid found. The urine is clear amber, acid, sp. gr. 1.027, neither albumin, sugar, nor bile pigment is found. Microscopically, also, nothing is found except normal constituents of the urine. His temperature is normal.

The diagnosis here lay, first, between a tumor of the liver; second, of the pylorus; third, possibly of the omentum; and, fourth, on account of its apparently superficial position, that it might possibly be a tumor of the abdominal wall. Careful examination showed that it was movable in relation to the abdominal wall, and, therefore, was certainly not connected with it. The absence of all gastric symptoms, vomiting, dyspepsia, retained food, dilatation of the stomach, etc., militated, in the opinion of Prof. Wilson and myself, against its being pyloric, or, in fact, any form of gastric tumor. Omental tumors are not, as you know, very common. Hepatic tumors are much more common. The presumption, therefore, simply on the doctrine of chances, was rather in favor of its being hepatic. The man's admission of the very frequent possibility of syphilitic infection should weigh very seriously with us, although he denies, at least, any knowledge of such an infection. The absence of marked hepatic disturbance itself would look toward a syphi-

litic gumma. Were it a cancerous nodule, the pain would be much greater, and there would be more disturbance of his general health, and probably, or at least possibly, some disturbance of the hepatic function. Percussion gave us but little information, but auscultation was of greater value, especially in limiting it probably to the liver. The phonendoscope would seem to indicate that it is hepatic, as, while the phonendoscope was upon the tumor, tapping upon the liver at any point gave us a marked resonance, whereas when we left the liver the resonance diminished very much. We made, therefore, a tentative diagnosis of a gumma of the liver, and placed the patient upon iodide of potassium, beginning with 10 grains three times a day, and gradually increased it until there was evidence of improvement. To-day I am very glad to show you the result: the tumor itself is still there, but it has diminished very much in size, so that it is just perceptible, and presumably will disappear, therefore, entirely; and the man's general health has so much improved that he is anxious to get back to his work. He has steadily taken the iodide for four weeks, the dose having been gradually increased until he has of late taken a drachm three times a day. It is not uncommonly a pretty safe practice to remember, when you have obscure tumors, to place the patient on iodide of potassium. The denial of syphilis is very common, but if the diagnosis is obscure it will do little, if any, harm to give the iodide; and sometimes it will prove that the patient lied, and, at the same time, will cure him.

The second case that I shall show you is one of

PAGET'S DISEASE OF THE NIPPLE FOLLOWED BY CANCER OF THE BREAST.

Her history is as follows: Mrs. D., age sixty-two, Bath Run, Pennsylvania. Was admitted to the Jefferson Hospital November 22, 1896. Her mother died at seventy-eight from influenza; her father at sixty-nine from apoplexy; 6 brothers and sisters are living and in good health. She was married at twenty-seven and has had 7 children. She

never had any trouble with the breast in nursing her children. In March, 1895, she noticed a small crust at the apex of the left nipple. By January, 1896, instead of healing, this had become redder, and exuded a sticky discharge, with some burning in the diseased area. In the summer of 1896, sharp shooting pain developed in the left breast itself, and about that time the whole nipple sloughed off. She has observed for the last three months that the breast has grown rapidly and the pain has become much more severe. On examination I found that both breasts were very large; in the left one, there was a distinct tumor to be felt in the upper outer quadrant, movable, slightly nodulated, and dense in structure. The nipple is gone and a fissure has replaced it. From this fissure there is a moderate amount of clear, watery, but glutinous discharge. The glands in the axilla are indistinctly felt.

The diagnosis in this case is easy. There is no retraction of the nipple, so frequently insisted on in cancer of the breast, for the reason that there is no nipple; it has dropped off, having been ulcerated away. The disease with which this woman was first attacked for twenty-one months is that known by various synonyms, as chronic eczema of the nipple, psoriasis of the nipple, or Paget's disease of the nipple. Whenever you have a woman, especially if she is approaching or past forty, with a chronic ulceration of the nipple, be very watchful of such a case. Should it not heal after a reasonable time, you may be almost sure that you have to deal with a form of disease which most pathologists now believe to be an epithelioma of the nipple, and which, certainly in very many cases, is the beginning of cancerous disease of the entire breast. In this very case, you see that it has been followed by a large, hard nodule of undoubted cancer in the breast. Not long since I operated upon a case in which thirteen years had elapsed from the beginning of the ulceration of the nipple. But not only in the nipple, but if on the lip, the anus, on the hands, the foot, in fact anywhere in the body, an ulcer is chronic and does not get well

within a few weeks, your suspicions as to its cancerous nature should be aroused, and you should investigate it with great care; if need be by excision of a piece for microscopical examination. Only one exception occurs to me to this rule, and that is the very common and very chronic ulceration which develops just above the ankle, and especially above the inner malleolus. These are often long-continued chronic ulcers without any tendency, excepting in very rare cases, to become malignant.

The operation that I shall do is that of Halsted's; namely, removal of the breast, both pectoral muscles, and all the contents of the axilla, excepting the blood-vessels and nerves, all in one piece. In so large a breast as this the operation is necessarily difficult, long, and we will have rather more bleeding than usual. As you see, however, as I go along, no very special trouble has arisen. I am always, however, afraid of another trouble in such very fat breasts—that we may have necrosis of the fatty tissue even without any primary infection. This I have seen repeatedly, together with a very sour butyric smell from the fermentation accompanying the necrosis.

Before the operation no glands could be felt, but the operation has revealed a number of glands about the size of buck-shot, especially just below the clavicle and in immediate juxtaposition to the vessels. The supraclavicular glands are not involved and I therefore did not remove them.

After-history.—The patient was entirely well and the stitches out within a week, her highest temperature having risen only once to 100°. The microscopical diagnosis reported by Dr. Rhoads, the pathological and bacteriological assistant in the surgical clinic, was that both the nipple and the breast were carcinomatous of the scirrhus variety, and some of the supposed small glands in the axilla were in reality aggregations of carcinomatous cells.

The third case that I shall show you is one of

TUBERCULOSIS OF THE TONSIL AND THE SOFT PALATE.

You will notice the order in which I have shown these patients: First, the patient upon whom no operation was done; second, the breast case, which was a clean, aseptic operation from the beginning; and, third, the operation on the mouth, where my fingers would necessarily be carried into the mouth and become more or less soiled. Had I operated on the breast case last, the soiling might have been carried over to the breast case in spite of intervening disinfection of the hands. The rule in our clinic, as you know, is always the clean cases first; infected cases last.

The patient's history is as follows: His father and mother died from unknown causes at eighty-seven and seventy years respectively; two sisters died in childhood and three brothers and sisters are living and in good health. With the exception of malaria at twenty-six, he has always enjoyed good health till six years ago, since which time he has complained of sore throat, especially on the left side, which pained him especially on swallowing any hard food. About six weeks ago, he noticed a small tumor under the angle of the jaw on the left side. With this there has been an increased dull pain in the left tonsil, with a constant desire to swallow. The urine is normal.

On examining the throat, the nature of the trouble is very quickly seen. The entire left tonsil presents an ulcer, the ulceration extending from the soft palate nearly to the uvula by way of the anterior and posterior arches of the palate, and also, below the tonsil, extending down almost to the tongue and somewhat on the lateral wall of the fauces. By touch this is distinctly hard, and the tissues are infiltrated to a moderate distance around the growth. The appearance of the growth, together with the enlarged glands under the angle of the jaw, makes the diagnosis practically quite certain—that of epithelioma. It is, however, quite remarkable that the soreness, presumably from the disease in the tonsil, should have existed for so long a period as six years.

The treatment is quite as clear as the diagnosis; namely, extirpation both of the diseased tissues in the throat and of the enlarged glands. In fact, if the glands were not enlarged, I should decide,—just as in cases of cancer of the breast the axillary glands are always removed,—to make an incision under the jaw and remove all the submaxillary lymphatic glands which could be detected. We are sometimes apt to forget principles in rules. If it is right to remove the axillary glands in every case of malignant disease of the breast, the same should hold good in every other part of the body; glands under the jaw or in the neck should be removed in every case of malignant disease of the face, and the saphenous glands and the glands of the groin should also be removed in malignant disease of the foot or of the genitals.

The first step here will be removal of the glands in the neck. This can be accomplished as a primary operation, and without opening the mouth. In addition to this we can then determine whether it will be possible to remove the tonsil and the adjacent structures from the wound in the neck, or whether it will be best to attack them through the mouth.

Operation.—An incision was first made from just below the chin to the ear, passing a little below the angle of the jaw. One very large and several smaller but enlarged glands were removed. The dissection was made difficult by the fact that the large gland was very closely adherent to the jugular, and had displaced it and the carotid forward. When I had completed the removal of these glands, therefore, the jugular and the common, the external and the internal carotids, and the hypoglossal, as well as the spinal accessory nerves, were all exposed to view. I then passed my left forefinger into the mouth in contact with the ulcer and with my right forefinger in the wound under the jaw proceeded to explore the extent of the disease: how much thickening there was of the tissues, etc. I was struck with the fact that the two fingers were not very far apart, and it occurred to me that I might be able so far to dissect

or separate the diseased tissues of the pharynx from the deeper tissues of the neck by my right forefinger, guided by the left, as to free them to such a degree that I could both remove them without endangering the vessels or other structures, and, also, that the loosening of these tissues would enable me then to pull them forward in the mouth so far as to make them much more accessible. This I found to be perfectly true. All the diseased tissues were thrust inward toward the mouth and separated from the other deeper parts with a good deal of ease, especially guided and assisted by the other forefinger in the mouth. The patient was then placed in the Trendelenburg position, the mouth gagged widely open, the left cheek retracted very far by means of a cheek retractor, and I was then able, seizing the soft palate with a pair of toothed forceps, to cut away by my knife, first, a little over one-half of the soft palate, including the uvula, and then, as I proceeded downward and backward, to separate both arches of the palate, and, drawing well forward the excavated and ulcerated tonsillar tissues, to cut all these loose from the underlying tissues.

Not a single vessel required a ligature; pressure by gauze sponges dipped in hot water enabled me to check entirely the hemorrhage. I then was able to unite the margins of the mucous membrane perfectly well, and in that manner shut off the neck from the cavity of the mouth.

For the first three days the patient will be fed by a new and disinfected Nélaton catheter passed through the nostril and connected with a funnel by an additional piece of rubber tubing. Milk and broth will be fed to him, and when the meal is completed a little water will be passed into the stomach through the tube, so that when it is withdrawn no soiling of the wound will take place by the food.

Later History.—Primary union took place throughout the entire external wound, so that the stitches were removed and the wound was entirely healed at the end of a week. The wound in the throat was quickly healed. The patient was out of bed on the third day, and

felt so well that he wanted to go home immediately. His temperature never rose above 99.2°, excepting on one occasion.

This method of operating is, to me at least, entirely new. It is very rare to find a case in which the infiltration will be so slight, especially after so long a period as in this case, as to allow the diseased tissues to be easily separated from the parts underneath. I was, however, very much struck with the advantages of operating in this way in cases in which it is possible. It avoids splitting the cheek or dividing the jaw in order to remove the disease. A valuable lesson to learn from this case is the importance of shutting off the mouth cavity from that in the neck, whenever it is possible, by completely suturing the mucous membrane in the mouth. If this can be done, it prevents infection of the cervical wound by dropping through of saliva and mucus from the mouth, and promotes to a very large degree primary union. In fact, where the wounds cannot be shut off from each other, primary union in the cervical wound is rare in my experience.

Remarks.—I have thought it only just to publish this clinical lecture just as it was delivered, for the reason that, at the time, I fully believed the case to be one of epithelioma. Its hardness, its appearance, the enlarged gland under the jaw, which was not caseating, all convinced me that it was an epithelioma; so much so that I did not follow my usual practice of removing a small piece, under cocaine, for a microscopical diagnosis. I was greatly surprised, therefore, when Dr. Rhoads, the bacteriological and pathological assistant in the surgical clinic, and Prof. Coplin, informed me that the disease was tubercular, as illustrated in the accompanying drawing made by Dr. Bevan.

The result shows very clearly that it is wise in all cases in which a small piece of a tumor can be removed for microscopical examination that it should be done. So far as the treatment is concerned, it would not, I think, have been changed even had I known that it was tubercular. The disease was so extensive, and had been so long-continued, that I should

have extirpated it in either case. The result certainly leaves nothing to be desired; even the patient's voice is quite clear, and far less altered than I had anticipated it would be. The facility with which the diseased structures were separated from the underlying parts by the finger is explained also by the nature of the disease as disclosed by the microscope.



TONSIL SHOWING TUBERCLE OF A LYMEHOID FOLLICLE WITH BEGINNING DEGENERATIVE CHANGES. Beck, $\frac{1}{8}$ obj.; oc., A. The tubercle bacilli are drawn in from another specimen stained by carbo-fuchsin. Zeiss, $\frac{1}{2}$ obj.; oc., C.

REMARKS BY PROF. COPLIN.—Tuberculosis of the tonsil in an otherwise non-tubercular individual is certainly sufficiently rare to demand record. In patients having tuberculosis of the larynx or lungs implication of the pharynx, tonsils, or uvula may be expected (Isambert, B. Fränkel, Scheck). All authorities agree, however, as to the infrequency of primary tuberculosis of these parts.

Further, it is of unusual interest that the morbid process may be quiescent for an almost indefinite period, and that an outbreak may be long delayed. Indeed, it has been maintained by Dmochowski that the tonsil may be the seat of tubercular infection and permit extension to the gland of the neck without itself evincing any gross change. The microscope, however, shows us in this case

infiltration of the lymphoid follicles and the stroma by tubercle bacilli, and, where the infiltration is marked, degenerative changes in the lymphoid elements. An enormous excess of leucocytes in the stroma is one of the characteristic histological phenomena of tuberculosis of the tonsil ; the accompanying drawing shows this point. Where ulceration occurs

it is by coagulation necrosis in the lymphoid structure, secondary infection by other bacteria, and subsequent softening. In some cases involving the mucosa and the lymphoid structure as it overlies the muscular tissues of the uvula or pillars, the tubercles may be seen and a diagnosis made without any difficulty. Such cases are infrequent.

